CABINET FOR HEALTH AND FAMILY SERVICES

Department for Medicaid Services

Division of Policy and Operations

(Amended After Comments)

907 KAR 1:102. Advanced practice registered nurse services.

RELATES TO: KRS 205.520

STATUTORY AUTHORITY: KRS 194A.030(2), 194A.050(1), 205.520(3), 42 C.F.R. Part 493, 42 U.S.C. 1396a, b, c, d[~~, EO 2004-726~~]

NECESSITY, FUNCTION, AND CONFORMITY:[~~EO 2004-726, effective July 9, 2004, reorganized the Cabinet for Health Services and placed the Department for Medicaid Services and the Medicaid Program under the Cabinet for Health and Family Services.~~] The Cabinet for Health and Family Services, Department for Medicaid Services, has responsibility to administer the Medicaid Program. KRS 205.520(3) authorizes the cabinet, by administrative regulation, to comply with any requirement that may be imposed, or opportunity presented, by federal law to qualify for federal Medicaid funds[~~for the provision of medical assistance to Kentucky's indigent citizenry~~]. This administrative regulation establishes the provisions relating to advanced practice registered nurse services covered by the Medicaid Program[~~for which payment shall be made by the Medicaid Program in behalf of both the categorically needy and the medically needy~~].

Section 1. Definitions. (1) "Advanced practice registered nurse" or "APRN" is defined in

KRS 314.011(7).

(2) "Common practice" means an arrangement through[~~a contractual partnership in~~] which a physician and an APRN jointly administer health care services.

(3) "CPT code" means a code used for reporting procedures and services performed by medical practitioners and published annually by the American Medical Association in Current Procedural Terminology.

(4) "Department" means the Department for Medicaid Services or its designated agent.[~~(4) "Emergency medical condition" means a medical condition that manifests itself by acute symptoms of sufficient severity (including severe pain) that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in placing the health of the individual (or with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy, serious impairment to bodily functions, or serious dysfunction of a bodily organ or part.~~]

(5) "Enrollee" means a recipient who is enrolled with a managed care organization.

(6) "Face-to-face" means occurring:

(a) In person; or

(b) If authorized by 907 KAR 3:170, via a real-time, electronic communication that involves two (2) way interactive video and audio communication.

(7) "Federal financial participation" is defined by 42 C.F.R. 400.203.

(8) "Global period" means the period of time in which related preoperative, intraoperative, and postoperative services and follow-up care for a surgical procedure are customarily provided.

(9) "Incidental" means that a medical procedure:

(a) Is performed at the same time as a primary procedure; and

(b) Is clinically integral to the performance of the primary procedure.

(10) "Injectable drug" means an injectable, infused, or inhaled drug or biological that:

(a) Is not excluded as a non-covered immunization or vaccine;

(b) Requires special handling, storage, shipping, dosing, or administration; and

(c) Is a rebatable drug.

(11) "Integral" means that a medical procedure represents a component of a more complex procedure performed at the same time.

(12) "Locum tenens APRN" means an APRN:

(a) Who temporarily assumes responsibility for the professional practice of an APRN participating in the Kentucky Medicaid Program; and

(b) Whose services are billed under the Medicaid participating APRN's provider number.

(13) "Locum tenens physician" means a substitute physician:

(a) Who temporarily assumes responsibility for the professional practice of an APRN participating in the Kentucky Medicaid Program; and

(b) Whose services are billed under the Medicaid participating APRN's provider number.

(14) "Managed care organization" means an entity for which the Department for Medicaid Services has contracted to serve as a managed care organization as defined in 42 C.F.R. 438.2.

(15)[~~"Emergency services" means covered inpatient or outpatient services, including~~

~~emergency ambulance transport, furnished by a qualified provider if the services are needed to evaluate or stabilize an emergency medical condition that is found to exist using the prudent layperson standard. (6)~~] "Medically necessary" or "medical necessity" means that a covered benefit is determined to be needed in accordance with 907 KAR 3:130[~~shall be:~~

~~(a) Provided in accordance with 42 C.F.R. 440.230;~~

~~(b) Reasonable and required to identify, diagnose, treat, correct, cure, ameliorate, palliate, or prevent a disease, illness, injury, disability, or other medical condition, including pregnancy;~~

~~(c) Clinically appropriate in terms of amount, scope and duration based on generally accepted standards of good medical practice;~~

~~(d) Provided for medical reasons rather than primarily for the convenience of the recipient, caregiver, or the provider;~~

~~(e) Provided in the most appropriate location, with regard to generally accepted standards of good medical practice, where the service may for practical purposes be safely and effectively provided;~~

~~(f) Needed, if used in reference to an emergency medical service, to evaluate or stabilize an emergency medical condition that is found to exist using the prudent layperson standard; and~~

~~(g) If applicable, provided in accordance with early and periodic screening, diagnosis, and treatment (EPSDT) requirements established in 42 U.S.C. 1396d(r) and 42 C.F.R. Part 441 Subpart B for individuals under twenty-one (21) year of age~~].

(16) "Mutually exclusive" means that two (2) procedures:

(a) Are not reasonably performed in conjunction with one (1) another during the same patient encounter on the same date of service;

(b) Represent two (2) methods of performing the same procedure;

(c) Represent medically impossible or improbable use of CPT codes; or

(d) Are described in Current Procedural Terminology as inappropriate coding of procedure combinations.

(17)[~~(7)~~] "New patient" means a recipient[~~ene~~] who has not received professional services from the provider within the past[~~a~~] three (3) years[~~year period~~].

(18) "Provider" is defined by KRS 205.8451(8).

(19) "Provider group" means a group of at least:

(a) Two (2) individually licensed APRNs who:

1. Are enrolled with the Medicaid Program individually and as a group; and

2. Share the same Medicaid group provider number; or

(b) One (1) APRN and at least one (1) physician who:

1. Are enrolled with the Medicaid Program individually and as a group; and

2. Share the same Medicaid group provider number[~~(8) "Prudent layperson standard" means the criterion used to determine the existence of an emergency medical condition whereby a prudent layperson, who possesses an average knowledge of health and medicine, determines that a medical condition manifests itself by acute symptoms of sufficient severity (including severe pain) that the person could reasonably expect the absence of immediate medical attention to result in placing the health of the individual (or with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy, serious impairment to bodily functions, or serious dysfunction of a~~

~~bodily organ or part~~].

(20) "Rebatable drug" means a drug for which the drug's manufacturer has entered into or complied with a rebate agreement in accordance with 42 U.S.C. 1396r-8(a).

(21)[~~(9)~~] "Recipient" is defined by KRS 205.8451(9)[~~means an individual who has been determined by the Kentucky Department of Community Based Services to be eligible to have the Kentucky Medicaid Program make reimbursement for covered services~~].

(22) "Timely filing" means receipt of a Medicaid claim by the department:

(a) Within twelve (12) months of the date the service was provided;

(b) Within twelve (12) months of the date retroactive eligibility was established; or

(c) Within six (6) months of the Medicare adjudication date if the service was billed to Medicare.

Section 2. Conditions of Participation. (1) To participate in the Medicaid program as a provider, an APRN or provider group shall comply with:

(a) 907 KAR 1:005, 907 KAR 1:671, and 907 KAR 1:672; and

(b) The requirements regarding the confidentiality of personal records pursuant to 42 U.S.C. 1320d to 1320d-8 and 45 C.F.R. Parts 160 and 164.

(2) A provider:

(a) Shall bill the:

1. Department rather than the recipient for a covered service; or

2. Managed care organization in which the recipient is enrolled if the recipient is an enrollee;

(b) May bill the recipient for a service not covered by Medicaid if the provider in-

formed the recipient of non-coverage prior to providing the service; and

(c)1. Shall not bill the recipient for a service that is denied by the department on the basis of:

a. The service being incidental, integral, or mutually exclusive to a covered service or within the global period for a covered service;

b. Incorrect billing procedures including incorrect bundling of services;

c. Failure to obtain prior authorization for the service; or

d. Failure to meet timely filing requirements; and

2. Shall not bill the enrollee for a service that is denied by the managed care organization in which the recipient is enrolled if the recipient is an enrollee on the basis of:

a. The service being incidental, integral, or mutually exclusive to a covered service or within the global period for a covered service;

b. Incorrect billing procedures including incorrect bundling of services;

c. Failure to obtain prior authorization for the service if prior authorization is required by the managed care organization; or

d. Failure to meet timely filing requirements.

(3)(a) If a provider receives any duplicate payment or overpayment from the department or managed care organization, regardless of reason, the provider shall return the payment to the department or managed care organization **that issued the duplicate payment or overpayment.**

(b) Failure to return a payment to the department or managed care organization in accordance with paragraph (a) of this subsection may be:

1. Interpreted to be fraud or abuse; and

2. Prosecuted in accordance with applicable federal or state law.

(4)(a) A provider shall maintain a current health record for each recipient.

(b)1. A health record shall document each service provided to the recipient including the date of the service and the signature of the individual who provided the service.

2. The individual who provided the service shall date and sign the health record within seventy-two (72) hours from the date that the individual provided the service.

(5)(a) Except as established in paragraph (b) or (c) of this subsection, a provider shall maintain a health record regarding a recipient for at least six (6) years from the date of the service or until any audit dispute or issue is resolved beyond six (6) years.

(b) After a recipient's death or discharge from services, a provider shall maintain the recipient's record for the longer of the following periods:

1. Six (6) years unless the recipient is a minor; or

2. If the recipient is a minor, three (3) years after the recipient reaches the age of majority under state law.

(c) If the Secretary of the United States Department of Health and Human Services requires a longer document retention period than the period referenced in paragraph (a) or (b) of this section, pursuant to 42 C.F.R. 431.17, the period established by the secretary shall be the required period.

(6) If a provider fails to maintain a health record pursuant to subsection (4) or (5) of this section, the department shall:

(a) Not reimburse for any claim associated with the health record; or

(b) Recoup from the provider any payment made associated with the health record.

(7) A provider shall comply with 45 C.F.R. Part 164.

(8)(a)[~~may participate in Kentucky Medicaid by complying with the terms and conditions established in 907 KAR 1:671 and 907 KAR 1:672. (2)~~] A service provided by an APRN to a[~~Kentucky Medicaid~~] recipient shall be substantiated by **health**[~~**medical**~~] records signed by the APRN which correspond to the date and service reported on the claim submitted for payment to the:

1. Department if the claim is for a service to a recipient who is not an enrollee; or

2. Managed care organization in which the recipient is enrolled if the recipient is an enrollee[~~Kentucky Medicaid~~].

(b) If rendering services to a recipient in a hospital, an[~~(3) In addition to the requirements established in subsection (2) of this section, the~~] APRN shall document in the **health**[~~**medical**~~] record of the[a] hospitalized[~~Kentucky Medicaid~~] recipient that the APRN performed one (1) or more of the following:

1.[~~(a)~~] A personal review of the recipient's medical history;

2.[~~(b)~~] A physical examination;

3.[~~(c)~~] A confirmation or revision of the recipient's diagnosis;

4.[~~(d)~~] A visit with the recipient; or

5.[~~(e)~~] A discharge service for the recipient.

Section 3. APRN Covered Services. (1)(a) An APRN covered service shall be:

1.[~~(a)~~] A medically-necessary service furnished by an APRN through face-to-face[~~direct practitioner-patient~~] interaction between the **APRN**[~~**practitioner**~~] and the recipient except as established in paragraph (c) of this subsection; and

2.[~~(b)~~] A service which is:

a.[~~1.~~] Within the legal scope of practice of the APRN as specified in;

(i) 201 KAR 20:057; and

(ii) 201 KAR 20:059; and

b.[2.] Eligible for reimbursement by Kentucky Medicaid.

(b) Any service covered pursuant to 907 KAR 3:005 shall be covered under this administrative regulation if it meets the requirements established in paragraph (a) of this subsection.

(c) Face-to-face interaction between the APRN[~~practitioner~~] and recipient shall not be required for:

1. A radiology service;

2. An imaging service;

3. A pathology service;

4. An ultrasound study;

5. An echographic study;

6. An electrocardiogram;

7. An electromyogram;

8. An electroencephalogram;

9. A vascular study;

10. A telephone analysis of an emergency medical system or a cardiac pacemaker if provided under APRN direction;

11. A sleep disorder service;

12. A laboratory service; or

13. Any other service that is customarily performed without face-to-face interaction between the APRN[~~practitioner~~] and the recipient.

(2) The[~~Administration of anesthesia by an APRN shall be a covered service. (3)~~] prescribing of drugs by an APRN shall be in accordance with 907 KAR 1:019.

(3)[~~If a specific brand of prescription is determined by the APRN to be medically necessary for a patient, the certification procedure shall conform with the requirements established in 907 KAR 3:005.~~

~~(4)(a) The cost of the following injectables administered in a physician or independent practitioner's office shall be covered:~~

~~1. Rho (D) immune globulin injection;~~

~~2. Injectable anticancer chemotherapy administered to a recipient in accordance with 907 KAR 3:005;~~

~~3. Depo-Provera contraceptive injection if provided in an office setting;~~

~~4. Penicillin G and ceftriaxone injectable antibiotics; and~~

~~5. Epidural injection if administered in accordance with the requirements established in 907 KAR 3:005.~~

~~(b) The cost of injectables not specified in paragraph (a) of this subsection shall be covered in accordance with 907 KAR 1:019, Section 2.~~

~~(5) An outpatient laboratory procedure performed by an APRN who has been certified in accordance with 42 C.F.R. Part 493 shall be covered.~~

~~(6) An obstetrical and gynecological service shall be covered as follows:~~

~~(a) An annual gynecological examination;~~

~~(b) Prenatal care;(c)~~] A covered delivery service provided in a:

(a) Hospital[~~, which~~] shall include:

1. Admission to the hospital;

2. Admission history;

3. Physical examination;

4. Anesthesia;

5. Management of uncomplicated labor;

6. Vaginal delivery; and

7. Postpartum care; or

(b) Freestanding birth center shall include:

1. Delivery services in accordance with 907 KAR 1:180, Section 3(3); and

2. Postnatal visits in accordance with 907 KAR 1:180, Section 3(3).

(4)[~~(d) A routine newborn service to an infant born to a Kentucky Medicaid-eligible recipient;~~

~~(e) An insertion of an intrauterine device (IUD), including the cost of the device, or removal of the IUD; or~~

~~(f) The insertion of an implantable contraceptive capsule, including the cost of the contraceptive capsule and related supplies, or removal of the contraceptive capsule.~~

~~(7)~~] An EPSDT screening service shall be covered if provided in compliance with the periodicity schedule established in 907 KAR 11:034[~~shall be covered~~].

(5) Behavioral health services established in 907 KAR 15:010 that are provided by an APRN or provider group that is the billing provider for the services shall be:

(a) Provided in accordance with 907 KAR 15:010; and

(b) Covered in accordance with 907 KAR 15:010[~~(8) The standard for determining the existence of an emergency medical condition and the need for emergency services shall be:~~

~~(a) In accordance with 42 U.S.C. 1396u-2; and~~

~~(b) Based on the prudent layperson standard~~].

(6) An injectable drug that is listed on the Physician Injectable Drug List and that is administered by an APRN or provider group shall be covered.

Section 4. Service Limitations and Exclusions. (1)(a) A limitation on a service provided by a physician in accordance with 907 KAR 3:005 shall apply to services covered under this administrative regulation.

(b) A service that is not covered pursuant to 907 KAR 3:005 shall not be covered under this administrative regulation[~~if the service is provided by an APRN~~].

(2) The same service performed by an APRN and a physician on the same day within a common practice shall be considered as one (1) covered service.

(3)(a) Except as established in paragraph (b) of this subsection, coverage of a psychiatric service provided by an APRN shall be limited to four (4) psychiatric services per APRN, per recipient, per twelve (12) months.

(b) A service designated as a psychiatry service CPT code that is provided by an APRN with a specialty in psychiatry shall not be subject to the limit established in paragraph (a) of this subsection.

(4) The department shall not cover more than one (1) of the following evaluation and management services per recipient per provider per date of service:

(a) A consultation service;

(b) A critical care service;

(c) An emergency department evaluation and management service;

(d) A home evaluation and management service;

(e) A hospital inpatient evaluation and management service;

(f) A nursing facility service;

(g) An office or other outpatient evaluation and management service; or

(h) A preventive medicine service.

(5) Except for any cost sharing obligation pursuant to 907 KAR 1:604, a:

(a) Recipient shall not be liable for payment of any part of a Medicaid-covered service provided to the recipient; and

(b) Provider shall not bill or charge a recipient for any part of a Medicaid-covered service provided to the recipient.

(6)(a) In accordance with 42 C.F.R. 455.410, to prescribe medication, order a service for a recipient, or refer a recipient for a service, a provider shall be currently enrolled and participating in the Medicaid program.

(b) The department shall not reimburse for a:

1. Prescription prescribed by a provider that is not currently:

a. Participating in the Medicaid program pursuant to 907 KAR 1:671; and

b. Enrolled in the Medicaid program pursuant to 907 KAR 1:672; or

2. Service:

a. Ordered by a provider that is not currently:

(i) Participating in the Medicaid program pursuant to 907 KAR 1:671; and

(ii) Enrolled in the Medicaid program pursuant to 907 KAR 1:672; or

b. Referred by a provider that is not currently:

(i) Participating in the Medicaid program pursuant to 907 KAR 1:671; and

(ii) Enrolled in the Medicaid program pursuant to 907 KAR 1:672.

Section 5. Prior Authorization Requirements. The prior authorization requirements established in 907 KAR 3:005 shall apply to services provided under this administrative regulation.

Section 6. Locum Tenens. [~~(1)~~] The department shall cover services provided by a locum tenens APRN or locum tenens physician under this administrative regulation:

(1) If the service meets the requirements established in this administrative regulation; and

(2) In accordance with:

(a) 201 KAR 20:056; and [~~If an APRN for whom a locum tenens APRN is substituting has a specialty, the locum tenens APRN shall have the same or a similar specialty.~~]

(b) 201 KAR 20:057[~~ The department shall not reimburse for services provided by a locum tenens APRN who does not have the same or a similar specialty as the APRN for whom the locum tenens APRN is substituting~~].

Section 7. No Duplication of Service. (1) The department shall not reimburse for a service provided to a recipient by more than one (1) provider of any program in which the service is covered during the same time period.

(2) For example, if a recipient is receiving a speech-language pathology service from a speech-language pathologist enrolled with the Medicaid Program under 907 KAR 8:030, the department shall not reimburse for the same service provided to the same recipient on the same day by another provider enrolled with the Medicaid Program.

Section 8. Third Party Liability. A provider shall comply with KRS 205.622.

Section 9. Use of Electronic Signatures. (1) The creation, transmission, storage, and

other use of electronic signatures and documents shall comply with the requirements established in KRS 369.101 to 369.120.

(2) A provider that chooses to use electronic signatures shall:

(a) Develop and implement a written security policy that shall:

1. Be adhered to by each of the provider's employees, officers, agents, or contractors;

2. Identify each electronic signature for which an individual has access; and

3. Ensure that each electronic signature is created, transmitted, and stored in a secure fashion;

(b) Develop a consent form that shall:

1. Be completed and executed by each individual using an electronic signature;

2. Attest to the signature's authenticity; and

3. Include a statement indicating that the individual has been notified of his or her responsibility in allowing the use of the electronic signature; and

(c) Provide the department, immediately upon request, with:

1. A copy of the provider's electronic signature policy;

2. The signed consent form; and

3. The original filed signature.

Section 10. Auditing Authority. The department **or the managed care organization in which an enrollee is enrolled** shall have the authority to audit any:

(1) Claim;

(2) Health[~~, Medical~~] record;[,] or

(3) Documentation associated with the claim or **health**[~~**medical**~~] record.

Section 11. Federal Approval and Federal Financial Participation. The department's coverage of services pursuant to this administrative regulation shall be contingent upon:

(1) Receipt of federal financial participation for the coverage; and

(2) Centers for Medicare and Medicaid Services' approval for the coverage.

Section 12. Appeal Rights.[~~(1)~~] An appeal of a[~~negative action taken by the~~] department decision regarding:

(1) A recipient who is not enrolled with a managed care organization based upon an application of this administrative regulation[~~A Medicaid beneficiary~~] shall be in accordance with 907 KAR 1:563; or

(2) An enrollee based upon an application of this administrative regulation shall be in accordance with 907 KAR 17:010.

Section 13. Incorporation by Reference. (1) "Physicians Injectable Drug List", February 21, 2014, is incorporated by reference.

(2) This material may be inspected, copied, or obtained, subject to applicable copyright law:

(a) At the Department for Medicaid Services, 275 East Main Street, Frankfort, Kentucky, Monday through Friday, 8 a.m. to 4:30 p.m.; or

(b) Online at the department's Web site at www.chfs.ky.gov/dms/incorporated.htm.[~~(2) An appeal of a negative action taken by the department regarding Medicaid eligibility of an individual shall be in accordance with 907 KAR 1:560.~~

~~(3) An appeal of a negative action taken by the department regarding a Medicaid provider shall be in accordance with 907 KAR 1:671.~~]

907 KAR 1:102

REVIEWED:

4-2-15
Date

Lisa Lee, Commissioner
Department for Medicaid Services

APPROVED:

4/9/15
Date

Audrey Tayse Haynes, Secretary
Cabinet for Health and Family Services

## REGULATORY IMPACT ANALYSIS AND TIERING STATEMENT

Administrative Regulation Number: 907 KAR 1:102
Contact Person: Stuart Owen (502) 564-4321

(1) Provide a brief summary of:

(a) What this administrative regulation does: This administrative regulation establishes the Medicaid program coverage provisions and requirements regarding advanced practice registered nurse (APRN) services.

(b) The necessity of this administrative regulation: This administrative regulation is necessary to establish the Medicaid program coverage provisions and requirements regarding APRN services.

(c) How this administrative regulation conforms to the content of the authorizing statutes: This administrative regulation conforms to the content of the authorizing statutes by establishing the Medicaid program coverage provisions and requirements regarding APRN services.

(d) How this administrative regulation currently assists or will assist in the effective administration of the statutes: This administrative regulation will assist in the effective administration of the authorizing statutes by establishing the Medicaid program coverage provisions and requirements regarding APRN services.

(2) If this is an amendment to an existing administrative regulation, provide a brief summary of:

(a) How the amendment will change this existing administrative regulation: The amendments include creating a locum tenens (substitute provider) option for APRN practices; authorizing APRNs to form provider groups with physicians; incorporating by reference a list of injectable drugs covered in an APRN setting; clarifying that behavioral health services provided by an APRN that are covered pursuant to 907 KAR 15:010 (Coverage provisions and requirements regarding behavioral health services provided by independent providers) shall be provided and covered pursuant to 907 KAR 15:010; clarifying that all services covered pursuant to 907 KAR 3:005 (physicians services) shall be covered via this administrative regulation if the given service is within the scope of an APRN's licensure; and clarifying that DMS will not reimburse for a prescription prescribed by a provider that is not currently enrolled and participating in the Medicaid Program or for a service ordered or referred by a provider that is not currently enrolled and participating in the Medicaid Program. The amendment after comments deletes a requirement that if an APRN serves as a locum tenens for an APRN that has a specialty the locum tenens APRN must have a same or similar specialty; inserts a requirement, in lieu of the aforementioned requirement, that a locum tenens must be in accordance with 201 KAR 20:056 and 201 KAR 20:057 (Kentucky Board of Nursing administrative regulations); changes the term "medical record" to "health record" for consistency; and replaces the term "practitioner" with "APRN" in a couple of places; and clarifies that a duplicate payment or overpayment received by a provider must be returned to the managed care organization which sent the duplicate payment or overpayment.

(b) The necessity of the amendment to this administrative regulation: The amend-

ment is necessary to establish a locum tenens option for APRNs to enhance recipient access to services; to establish the option for an APRN to form a provider group with a physician to allow APRNs and providers more flexibility in establishing practices (which is expected to enhance recipient access to services); to update the injectable drugs covered under the Medicaid program by incorporating by reference the Physician Injectable Drug List; and to clarify provisions. The clarification regarding DMS not reimbursing for a prescription unless the prescriber is currently enrolled and participating in the Medicaid Program and not reimbursing for a service ordered or referred unless the provider who ordered or referred the service is currently enrolled and participating in the Medicaid Program is necessary to comply with a federal mandate. The locum tenens amendments are necessary as the prior requirement exceeded requirements placed on APRNs by the Kentucky Board of Nursing. The other amendments are necessary for consistency or clarity in language.

(c) How the amendment conforms to the content of the authorizing statutes: The amendment conforms to the content of the authorizing statutes by modernizing Medicaid standards for APRN practices; clarifying provisions, and complying with a federal mandate. The locum tenens amendments conform to the content of the authorizing statutes by synchronizing requirements with those established by the Kentucky Board of Nursing. Other amendments conform to the content of the authorizing statutes by adding clarity.

(d) How the amendment will assist in the effective administration of the statutes: The amendment will assist in the effective administration of the authorizing statutes by modernizing Medicaid standards for APRN practices; clarifying provisions, and complying with a federal mandate. The locum tenens amendments will assist in the effective administration of the authorizing statutes by synchronizing requirements with those established by the Kentucky Board of Nursing. Other amendments conform to the content of the authorizing statutes by adding clarity.

(3) List the type and number of individuals, businesses, organizations, or state and local government affected by this administrative regulation: The administrative regulation affects advanced practice registered nurses enrolled in the Medicaid program. Currently, there are 4,104 individual APRNs enrolled in Kentucky's Medicaid Program.

(4) Provide an analysis of how the entities identified in question (3) will be impacted by either the implementation of this administrative regulation, if new, or by the change, if it is an amendment, including:

(a) List the actions that each of the regulated entities identified in question (3) will have to take to comply with this administrative regulation or amendment: No action is required by providers.

(b) In complying with this administrative regulation or amendment, how much will it cost each of the entities identified in question (3): No cost is imposed on providers.

(c) As a result of compliance, what benefits will accrue to the entities identified in question (3): APRNs will benefit by being able to form a provider group with a physician, by being able to employ a locum tenens APRN to take over one's practice temporarily if necessary, and by the expansion of more injectable drugs covered in an APRN setting.

(5) Provide an estimate of how much it will cost to implement this administrative regulation:

(a) Initially: The Department for Medicaid Services (DMS) anticipates no additional cost as a result of the amendment.

(b) On a continuing basis: DMS anticipates no additional cost as a result of the amendment.

(6) What is the source of the funding to be used for the implementation and enforcement of this administrative regulation: The sources of revenue to be used for implementation and enforcement of this administrative regulation are federal funds authorized under the Social Security Act, Title XIX and matching funds of general fund appropriations.

(7) Provide an assessment of whether an increase in fees or funding will be necessary to implement this administrative regulation, if new, or by the change if it is an amendment: The current fiscal year budget will not need to be adjusted to provide funds for implementing this administrative regulation.

(8) State whether or not this administrative regulation establishes any fees or directly or indirectly increases any fees: This administrative regulation does not establish or increase any fees.

(9) Tiering: Is tiering applied? Tiering was not appropriate in this administrative regulation because the administrative regulation applies equally to all those individuals or entities regulated by it.

## FEDERAL MANDATE ANALYSIS COMPARISON

Administrative Regulation Number: 907 KAR 1:102
Contact Person: Stuart Owen (502) 564-4321

1. Federal statute or regulation constituting the federal mandate. 42 U.S.C. 1396a(a)(19), 42 C.F.R. 447.26, 42 C.F.R. 445.410.

2. State compliance standards. KRS 205.520(3) states, "Further, it is the policy of the Commonwealth to take advantage of all federal funds that may be available for medical assistance. To qualify for federal funds the secretary for health and family services may by regulation comply with any requirement that may be imposed or opportunity that may be presented by federal law. Nothing in KRS 205.510 to 205.630 is intended to limit the secretary's power in this respect."

3. Minimum or uniform standards contained in the federal mandate. 42 U.S.C. 1396a(a)(19) requires Medicaid programs to provide care and services consistent with the best interests of Medicaid recipients. 42 C.F.R. 455.410 requires state Medicaid Programs to require health care professionals who order services for Medicaid recipients or refer recipients to services to be currently enrolled and participating in the Medicaid Program.

4. Will this administrative regulation impose stricter requirements, or additional or different responsibilities or requirements, than those required by the federal mandate? The amendment does not impose stricter, additional or different requirements than those required by the federal mandate.

5. Justification for the imposition of the stricter standard, or additional or different responsibilities or requirements. Stricter requirements are not imposed.

## FISCAL NOTE ON STATE OR LOCAL GOVERNMENT

Administrative Regulation Number: 907 KAR 1:102
Contact Person: Stuart Owen (502) 564-4321

1. What units, parts or divisions of state or local government (including cities, counties, fire departments, or school districts) will be impacted by this administrative regulation? This amendment will affect APRNs enrolled in the Medicaid program.

2. Identify each state or federal statute or federal regulation that requires or authorizes the action taken by the administrative regulation. KRS 194A.030(2), 194A.050(1), 205.520(3), 42 C.F.R. 445.410.

3. Estimate the effect of this administrative regulation on the expenditures and revenues of a state or local government agency (including cities, counties, fire departments, or school districts) for the first full year the administrative regulation is to be in effect.

(a) How much revenue will this administrative regulation generate for the state or local government (including cities, counties, fire departments, or school districts) for the first year? This amendment will not generate any additional revenue for state or local governments during the first year of implementation.

(b) How much revenue will this administrative regulation generate for the state or local government (including cities, counties, fire departments, or school districts) for subsequent years? This amendment will not generate any additional revenue for state or local governments during subsequent years of implementation.

(c) How much will it cost to administer this program for the first year? DMS anticipates no additional cost as a result of the amendment.

(d) How much will it cost to administer this program for subsequent years? DMS anticipates no additional cost as a result of the amendment.

Note: If specific dollar estimates cannot be determined, provide a brief narrative to explain the fiscal impact of the administrative regulation.

Revenues (+/-):
Expenditures (+/-):
Other Explanation: No additional expenditures are necessary to implement this amendment.